Acceptance of Amendment/Correction Request

Insert Client Name and Address	Medicaid ID# or Soc. Sec. #
	Date Filed
	Date Processed

Dear (Client name):

Thank you for submitting your request for an amendment or correction of your health information.

- ❒ Your request has been accepted in full.
- ❒ Your request has been accepted in part. You will receive a separate letter about the area of your request that was denied.

The appropriate amendment to your protected health information and/or record has been made to your

_____record.

(i.e. eligibility, medical)

The amended information will be forwarded to the organizations or individuals you identified on your initial request. If you did not indicate that we forward the amended information, you may wish to do so by contacting: _____

(name, department, address, and phone number)

Sincerely,

Name
Job Title

c: Case File

Sample Form: The Program / Office Mailing Address must be added.